



Select location:

- |                        |                           |                    |                       |
|------------------------|---------------------------|--------------------|-----------------------|
| Akron                  | Cleveland (Mayfield)      | Dayton (Englewood) |                       |
| Anderson               | Cleveland (North Olmsted) | Findlay            |                       |
| Athens                 | Columbus (East Broad)     | Liberty            |                       |
| Canton                 | Columbus (Hilliard)       | Mansfield          | Toledo                |
| Cincinnati (Blue Ash)  | Columbus (Worthington)    | Perrysburg         | Warren                |
| Cincinnati (West Side) | Dayton (Beavercreek)      | Springfield        | Crestview Hills (NKY) |

**For new referrals, please include recent labs and last two office visit notes**

**Fax completed form to 888-977-0914**

Phone: 877-787-8720 • www.horizoninfusions.com

**1. PATIENT INFORMATION**

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M      F	Weight:	Lbs      Kg
Patient Status:	New to therapy      Continuing therapy	Next due date (if applicable):	

**2. INSURANCE INFORMATION (required)**

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

**3. PHYSICIAN INFORMATION**

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

**4. DIAGNOSIS INFORMATION (ICD 10 Code Required)**

Generalized Myasthenia Gravis (gMG) ( \_\_\_\_\_ )      Other \_\_\_\_\_

**5. PRESCRIPTION INFORMATION (requires new order every 12 months)**

Dosing: SQ infusion once weekly x 6 weeks

Body Weight of Patient	Dose
Less than 50 kg	420 mg
50 kg to less than 100 kg	560 mg
100 kg and above	840 mg

Administer subsequent treatment cycles based on clinical evaluation; no sooner than 63 days from the start of the previous treatment cycle.

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

**PRE-MEDICATIONS**      N/A

Acetaminophen      500mg      650mg      1000mg

Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)

Diphenhydramine (Benadryl)      25mg      50mg      PO      IV (requires driver)

Methylprednisolone (Solu-Medrol)      40mg      80mg      125mg IV

Prednisone \_\_\_\_\_ mg PO

Other \_\_\_\_\_

**POST-MEDICATIONS**      N/A

Acetaminophen      500mg      650mg      1000mg

Prednisone \_\_\_\_\_ mg PO

Other \_\_\_\_\_

**6. LABS**

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

**7. SIGNATURE (required)**

PHYSICIAN'S SIGNATURE

DATE